STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325076	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony Healthcare and Rehabilitation Center	1400 West 21st Street Clovis, NM 88101

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure safe medication storage practices by not ensuring the following:1. The medication carts were locked while unattended, 2. The medical supply storage rooms were kept free of expired medications, 3. Supplies and medications were stored according to manufacturer's temperature instructions. These deficient practices have the potential to affect all 61 residents as identified by the census provided by the Activities Coordinator on 08/10/25. If the facility does not ensure safe storage practices, then residents are at risk for unauthorized persons to have access to medications and adverse effects due to improper storage. The findings are: Medication Carts:A. On 08/10/25 at 10:22 am, during an observation of the facility, the medication cart located near the nurse's station was found unlocked and unattended. B. On 08/10/25 at 10:25 am, during an interview with Registered Nurse (RN) #1, he confirmed that the medication cart near nursing station was not locked and should be. C. On 08/11/25 at 8:30 am, during an observation of the facility, the medication cart in main hallway was found unlocked and unattended. D. On 08/11/25 at 8:33 am during an interview with Licensed Practical Nurse (LPN) #2, she confirmed the medication cart was left unlocked while unattended. E. On 08/11/25 at 11:55 am during an observation of the facility, the medication cart in main hallway was found unlocked and unattended. F. On 08/11/25 at 11:57 am, during an interview with LPN #2, she confirmed the medication cart was unlocked while unattended. Medication Storage: G. On 08/13/25 at 12:04 pm, during observation of medication cart by nursing station, a medication named Nitroglycerin issued 06/14/24, had an expiration date of 06/25. H. On 08/13/25 at 12:10 pm, during a medical storage observation revealed the following:1. Three boxes of Influenza vaccines had an expiration date of 06/30/25.2. Two indwelling catheter securement devices named Uro-secure had an expiration date of 09/30/24.3. Two intravenous secondary administration sets had an expiration date of 08/12/25.4. A bottle of Magnesium oxide 400 mg bottle had an expiration date of 07/2025.5. A bottle of Acidophilus with a date opened date of 06/15/25, the bottle indicated it should be refrigerated after opening but was located on the shelf in the medication room, not refrigerated. 6. Ten tubes of Hemorrhoidal cream had an expiration date of 08/25. I. On 08/13/25 at 12:25 pm, during an interview with LPN #1, she confirmed the expired medications should be properly disposed of and the unrefrigerated medication should have been refrigerated.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interviews, the facility failed to ensure the nutritional needs and preferences were met for all 61 residents listed on the facility census provided by the Administrator (ADM) on 08/10/25, when staff failed to complete the following: 1. Serve food items that were listed on the menu. 2. Provide residents with the opportunity to select their choice from the menu or alternate menu in advance of meal service. These deficient practices are likely to lead to residents experiencing frustration, depression, and weight loss due to not knowing what food is being served or being able to choose what they eat. The findings are: A. Record review of the posted lunch menu for 08/10/25 revealed the following food items listed to be served:1. Main menu had herb crusted roast pork, dinner roll, baked potato, green beans and onions.2. Alternate item for herb crusted roast pork was meatballs. 3. Dessert was cinnamon cheesecake. B. On 08/10/25 at 12:52 pm, observation of the lunch meal revealed turkey and mashed potatoes, or quiche, dinner roll, and tater tots were served as the meal, with no dessert served. C. On 08/10/25 at 1:00 pm, during an interview with the Dietary Manager (DM), she confirmed the lunch meal served did not match the food items listed on the menu. D. On 08/10/25 at 12:50 pm, an interview and observation with R #8 revealed the following: 1. Meal ticket indicated an egg and sausage casserole with white toast, sliced pears, and oven browned potatoes were to be served. 2. Meal served was observed to include eggs with cheese, a white dinner toll, tater tots and peaches. 3. R #8 stated he doesn't even look at the meal tickets or the menus because the facility doesn't follow it.E. On 08/11/25 at 12:38 pm, observation of the lunch menu revealed a burrito, broccoli salad, dinner roll and a mixed fruit cup to be served. The meal that was served included a burrito, peas, bread slices and sliced bananas instead. F. On 08/11/25 at 1:06 pm, during an interview with the DM, she confirmed that the menu is not always followed, stating the staff do their best to make comparable food items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain the kitchen in a sanitary manner when staff failed to complete the following: 1. Maintain the ice machine in a manner to prevent contamination and foodborne pathogens, 2. Maintain the coffee, juice, and tea machines in a clean and sanitary manner, 3. Properly store food items,4. Maintain the kitchen environment in a clean and sanitary manner.These failures have the potential to result in cross contamination, the growth of foodborne pathogens, and foodborne illnesses. The findings are: A. On 08/10/25 at 10:00 am, a random observation of the kitchen revealed the following: 1. The ice machine was approximately three quarters of the way full of ice, had dried residue on the inside of the machine and what appeared to be dried food particles and splatters on the outside of the machine. 2. The coffee, juice, and tea machines were visibly dirty with dried spills and splatters on them.3. A sign on the door of the walk-in refrigerator indicates it is out of service. The walk-in refrigerator contained two boxes of molded biscuits, a box of individual portioned packages of whipped butter spread, one box of corn tortillas, one box of hot dog buns, two gallons of water, and one half used gallon of sweet and sour sauce. 4. The floor in its entirety was visibly dirty with trash, food particles, dried fluid spills, and dirt. 5. The walls and backsplash behind the sink and stove were visibly dirty with spills and splatters. 6. The counter tops in the kitchen were visibly soiled with food particles, trash, and dried spills and splatters on them. B. On 08/10/25 at 10:41 am, an interview with the Dietary Manager (DM) confirmed the following: 1. The ice machine, coffee machine, juice machine, and tea machines are visibly dirty. 2. The floors in the kitchen area were visibly dirty. 3. The food items being stored in the walk-in refrigerator are not stored properly and should be.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by not providing the following:Enhanced Barrier (EBP) signs not visible outside of rooms with precautions,Hand Sanitizing,This failed practice has the potential to result in the spread of infectious diseases and residents to be at risk of contracting infections, hospitalization, and death. The findings are:Enhanced BarriersA. On 08/10/25 at 10:22 am, during a random observation of the facility, Personal Protective Equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) were hanging on the doors outside rooms 200, 202, 205, 215, 217, and 222. Enhanced barrier precaution signs for rooms [ROOM NUMBERS] were not visible and were found tucked behind yellow PPE gowns.B. Record review of Infection control policies and procedures dated 07/15/25, indicated to refer to Centers for Disease Control and Prevention (CDC). C. Record review of CDC guidelines from CDC website Enhanced Barrier Precautions (EBP) in Nursing Homes. Centers for Disease Control. https://www.cdc.gov/infection-control /Webinar-EBPinNH-Nov2022-Slides-508.pdf on Slide number 28 Communication - Use appropriate and legible signs for precautions, the CDC recommends that EBP signs be displayed outside the door of the room where EBP is required. The sign should indicate the type of precaution and PPE to be used during high-contact resident care activities.D. On 08/12/25 at 11:35 am during an interview with Administrator/Infection Control, she stated signs should be in place in a way that they are visible and confirmed they are not. Hand SanitizingD. On 08/11/25 at 12:30 pm, an observation of the lunch dining services revealed the following: 1. CNA #5 touched a resident's right arm/shoulder, picked up a cup that was dropped on the floor, opened the kitchen door that leads to the dirty dishes section, placed the cup in the dirty dish container and then served R #35 lunch without sanitizing or washing her hands. 2. CNA #4 touched her head/hair and neck/shoulder demonstrating something while telling a story then served R #47 her lunch without sanitizing or washing her hands. E. On 08/11/25 at 12:56 pm, during an interview with Registered Nurse (RN) #1, he confirmed that staff should be sanitizing or washing their hands after touching dirty surfaces and handling food trays.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to maintain documentation related to staff COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) vaccinations (treatment with a vaccine to produce immunity to a particular infections disease or pathogen) for 4 (CNA #1, CNA #2, CNA #3, and CNA #4) of 4 (CNA #1, CNA #2, CNA #3, and CNA #4) staff members reviewed for COVID-19 vaccinations and at a minimum provide the following:1. Staff were given education of the COVID-19 vaccination regarding the benefits and potential risks associated with COVID-19 vaccine,2. Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine. 3. Staff were given opportunity to decline the COVID-19 vaccination.This deficient practice could likely result in staff not having the knowledge or opportunity to get needed vaccinations. The findings are:CNA #1'sA. Record review of CNA #1's personnel file revealed: 1. The record did not contain CNA #1's COVID-19 immunization history.2. The record did not contain documentation that CNA #1 received education about the COVID-19 vaccination.3. The record did not contain documentation of CNA #1 being given the opportunity to refuse or accept the COVID-19 vaccination. CNA #2B. Record review of CNA #2's personnel file revealed: 1. The record did not contain CNA #2's COVID-19 immunization history.2. The record did not contain documentation that CNA #2 received education about the COVID-19 vaccination.3. The record did not contain documentation of CNA #2 being given the opportunity to refuse or accept the COVID-19 vaccination. CNA #3'sC. Record review of CNA #3's personnel file revealed: 1. The record did not contain CNA #3's COVID-19 immunization history.2. The record did not contain documentation that CNA #3 received education about the COVID-19 vaccination.3. The record did not contain documentation of CNA #3 being given the opportunity to refuse or accept the COVID-19 vaccination. CNA #4D. A. Record review of CNA #4's personnel file revealed: 1. The record did not contain CNA #4's COVID-19 immunization history.2. The record did not contain documentation that CNA #4 received education about the COVID-19 vaccination.3. The record did not contain documentation of CNA #4 being given the opportunity to refuse or accept the COVID-19 vaccination.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure essential equipment was in safe operating condition by not cleaning, repairing, or replacing the following: 1. The cleaning solution dispenser above the three-compartment sink.2. The walk-in refrigerator. 3. The freezer located in the kitchen. 4. The water heater located in the kitchen. If the facility does not keep essential equipment in the kitchen in safe operating condition, then all 61 residents residing in the facility (according to the facility census that was provided by the administrator (ADM) on 08/10/25) could experience increase in foodborne illnesses and food not being prepared properly. The findings are:A. On 08/10/25 at 10:00 am, a random observation of the kitchen revealed the following: 1. The cleaning solution dispenser above the three-compartment sink had a cloth tied around it with water pouring from it into the sink. 2. A sign on the door of the walk-in refrigerator indicated it was out of service. The walk-in refrigerator contained two boxes of molded biscuits, a box of individual portion packages of whipped butter spread, one box of corn tortillas, one box of hot dog buns, two gallons of water, and one half used gallon of sweet and sour sauce. 3. The bottom vent of the freezer in the kitchen fell off as the freezer door was opened exposing the wires and mechanical parts under the freezer. B. On 08/10/25 at 10:41 am, an interview with the Dietary Manager (DM) she confirmed that the cleaning solution dispenser located above the three-compartment sink was pouring water from the hose and it is not supposed to. The DM stated that the walk-in refrigerator is not working so it is being used for storage. The DM confirmed the walk-in refrigerator contained two boxes of molded biscuits that need to be disposed of. The DM confirmed the food items stored in the walk-in and stated the walk-in refrigerator does not meet her expectations because it is broken and is being used inappropriately to store food items.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to report the results of all investigations to the State Survey Agency within five working days of an incident for 2 (R #32 and R #64) of 2 (R #32 and R #64) residents reviewed for abuse or neglect. If the facility is not submitting the summary of the facility's investigation to the State Survey Agency, then the State Survey Agency is unable to appropriately triage (review) the allegation for further investigation. The findings are:R #32A. Record review of the facility's list of reportable incidents revealed an incident for R #32 dated 05/15/25. Review of this incident revealed the facility received an extension to submit the five-day report, making the due date 05/27/25. B. Record review of the facility's five-day report revealed the facility failed to meet the extended due date as it was completed and submitted to the State Survey Agency on 06/09/25.R #64C. Record review of the facility's list of reportable incidents revealed an incident for R #64 dated 05/12/25. Review of this incident revealed the facility received an extension to submit the five-day report, making it due 05/28/25. D. Record review of the facility's five-day report revealed the facility failed to meet the extended due date as it was completed and submitted to the State Survey Agency on 06/02/25.E. On 08/14/25 at 9:17 am, during an interview with the Administrator (ADM), she stated she is the facility's Incident Coordinator, so it is her responsibility to ensure every allegation of abuse and neglect is investigated and to submit the follow-up report to the State Survey Agency within five days. The ADM confirmed that did not happen for the incident regarding R #32 on 05/15/25 and for the incident regarding R #64 on 05/12/25.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep residents free from physical restraints for 1 (R #4) of 1 (R #4) resident reviewed for restrictions when staff used a wander guard (wearable technology used to keep residents from wandering or eloping from the facility unattended) for a resident that no longer needs a wander guard. This deficient practice could likely result in R #4 being unnecessarily restricted. The findings are: A. Record review of R #4's admission Record revealed R #4 was admitted to the facility on [DATE], with the following diagnoses:1. Dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance (marked by a severe decline in cognitive functions, such as thinking, reasoning, and remembering, to the extent that it interferes with the person's daily life), 2. Thyrotoxicosis, unspecified without thyrotoxic crisis or storm (too much thyroid hormone in your body. Common symptoms include unexplained weight loss, a rapid heart rate and shakiness),3. Gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining),4. Longterm (current) use of insulin (an essential hormone that helps your body turn food into energy and manages your blood sugar levels),5. History of falling,6. Need for assistance with personal care.B. Record review of R #4's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 06/18/25, revealed:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 12 (mildly impaired). 2. Section E-Behavior revealed R #4 is not at risk for wandering.C. Record review of R #4's elopement evaluation dated 07/23/25 revealed R #4 does not have a history of elopement, nor has he attempted to leave the facility without informing staff.D. On 08/13/25 at 1:08 pm observation of R #4 revealed he had a wander guard on his right ankle. E. On 08/13/25 at 1:09 pm during an interview with R #4, he stated he wasn't sure why he had a wander guard on. F. Record review of R #4's current physician orders revealed an order dated 02/10/25 for R #4 to wear a wander guard on his left ankle for poor safety awareness. G. On 08/13/25 at 1:22 pm during an interview with the Administrator (ADM), she stated R #4 does not exhibit any behaviors for a wander guard and should not have one in place. H. On 08/13/25 at 1:23 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated R #4 does not exhibit any signs of wandering and should not have one in place. I. On 08/13/25 at 1:24 pm during an interview with Certified Rehabilitation Counselor (CRC) #1, she stated R #4 does not exhibit any behaviors that would require a wander guard and agreed he should not have one in place.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff revised the care plan for 1 (R #32) of 3 (R #9, R #32, and R #65) residents reviewed when staff failed revise R #34's care plan to include elopement risk and use of a wander guard (wearable technology used to keep residents from wandering or eloping from the facility unattended). This deficient practice is likely to result in residents' care and needs not being addressed. The findings are: A. Record review of R #32's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Other pulmonary embolism (a blood clot that blocks blood flow to an artery in the lungs),2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 3. Schizoaffective disorder (a mental condition that causes both psychosis and mood problems),4. Essential (primary) hypertension (HTN; high blood pressure),B. On 08/10/25 at 11:00 am an observation of R #32 revealed a wander guard located on R #32's wheelchair. C. Record review of R #32's progress note dated 07/01/25 revealed R #32's guardian was contacted and approved of the use of a wander guard due to increased elopement behaviors by R #32. D. Record review of R #32's care plan dated 04/08/25 revealed the care plan did not contain any indication of R #32's elopement risk or use of a wander guard. E. On 08/13/25 at 1:15 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed the following: 1. R #32 does use a wander guard due to an increase in elopement behaviors. 2. R #32's care plan does not include R #32's elopement risk or use of a wander guard.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to post nurse staffing data daily, at the beginning of the shift that included the following: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered nurses. 2. Licensed practical nurses. 3. Certified nurse aides. 4. Resident census. This deficient practice could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 08/10/25 at 10:00 am, an observation of the main entrance revealed the nurse staffing data sheet was dated 08/08/25. B. On 08/13/25 at 1:22 pm, during an interview with the Administrator, she confirmed the nursing staffing data sheet should be posted daily and it was not.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, record review, and interviews, the facility failed to ensure residents were free from significant medication errors by not administering medications as ordered for 1 (R #2) of 1 (R #2) resident reviewed for medication administration. This deficient practice could likely lead to severe negative effects on the residents. The findings are: A. Record review of R #2's admission Record revealed she was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease (PVD; poor circulation) and heart failure. B. On 08/13/25 at 11:15 am, an observation and interview with R #2 revealed that she had not received her Lidocaine External Patch and she had no wraps on her legs. C. Record review of R #2's current physician orders revealed the following orders:1. Lidocaine external patch to be applied to her upper back topically in the morning for back pain, end date of 08/31/25.2. An order dated 01/03/25 to wrap R #2's bilateral legs with an ACE bandage daily for edema (swelling caused by excess fluid) and is to be completed daily at 6:00 am.D. Record review of R #2's Medication Administration Record (MAR) for the month of August 2025 revealed Licensed Vocational Nurse (LVN) #4 signed the MAR on 08/13/25 at 10:13 am that indicated the following 1. She applied the Lidocaine external patch on R #2's back. 2. She wrapped R #2's bilateral legs with ACE bandages at 6:00 am. E. On 08/13/25 at 11:23 am during an interview with the Unit Manager (UM) #1, she confirmed R #2 had not received her Lidocaine external patch and that her legs were not wrapped. UM #1 confirmed that LVN #4 signed R #2's MAR indicating that both orders were followed, and they were not. The UM confirmed that LVN #4 not following medical orders and indicated on the MAR that she had, is considered a significant medication error that should not have occurred.